TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
RICKY MCSHANE, DO

Respondent Name
AMERICAN CASUALTY COMPANY OF READING PENNSYLVANIA

MFDR Tracking Number
M4-17-0130-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
September 12, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The EOR/Denials state that the rendering/billing provider, Dr. Ricky McShane, is not on the 'Approved Doctor List.' . . . We have contacted the Texas Division of Workers Compensation and were told by a Healthcare Specialist that the 'Approved Doctor List' was discontinued in 2007."

Amount in Dispute: $110.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As reflected in the attached EOBs, American Casualty's denial of reimbursement in this case was consistent with the applicable provisions of the Texas Workers' Compensation Act and Division's Rules. Accordingly, Dr. McShane is not entitled to reimbursement for the disputed services."

Response Submitted by: Burns Anderson Jury & Brenner, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 24, 2016	Evaluation and Management Service 99213, Work Status Report 99080	$110.00	$110.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §126.8 establishes the division's former Approved Doctor List.
4. 28 Texas Administrative Code §129.5 governs the filing of and payment for work status reports.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B7 – THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE.
   - 811 – CHARGES DENIED BECAUSE ON THIS DATE OF SERVICE, PROVIDER WAS NOT ON THE APPROVED DOCTOR LIST.

Issues

1. Are the insurance carrier's denial reasons supported?
2. What is the recommended reimbursement for the disputed work status reports?
3. What is the recommended reimbursement for the disputed evaluation and management services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied payment for the disputed services with claim adjustment reason codes:
   - 811 – CHARGES DENIED BECAUSE ON THIS DATE OF SERVICE, PROVIDER WAS NOT ON THE APPROVED DOCTOR LIST.
   - B7 – THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE.

   The respondent asserts "As reflected in the attached EOBs, American Casualty's denial of reimbursement in this case was consistent with the applicable provisions of the Texas Workers' Compensation Act and Division's Rules. Accordingly, Dr. McShane is not entitled to reimbursement for the disputed services."

   The Commission [now the division] Approved Doctor List, as found in former 28 Texas Administrative Code §126.8, no longer exists; per Rule §126.8(c), that section was no longer effective on or after September 1, 2003.

   The respondent did not submit a copy of the alleged approved doctor list—or documentation that the health care provider was not approved on the date of service—to support the insurance carrier's denial reasons.

   For the above reasons the division finds that the insurance carrier's denial reason code 811 – "CHARGES DENIED BECAUSE ON THIS DATE OF SERVICE, PROVIDER WAS NOT ON THE APPROVED DOCTOR LIST," is not supported.

   Furthermore, according to division consent order DWC-12-0089, dated May 30, 2012, this provider was removed as a *designated* doctor (and would not re-credential to apply to be on the designated doctor list). Additionally, he was deprived of the right to certify maximum medical improvement and/or assign impairment ratings in the workers' compensation system for a period of one year. That one year duration has since elapsed and the doctor may now certify maximum medical improvement and/or assign impairment ratings. Although this provider may not be designated by a treating doctor to perform required medical examinations or perform designated doctor duties, no such services are in dispute.

   As the services in dispute are not designated doctor services, the carrier's denial reason B7 – "THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE" is not supported.

   Based on the preponderance of the information presented by the parties, the insurance carrier's denial reasons are not supported. The division finds the medical provider was not ineligible or disqualified from performing the disputed services on the dates of service. Accordingly, the disputed services will be reviewed for payment according to applicable division rules and fee guidelines.

2. This dispute regards, in part, payment for a work status report, billed under procedure code 99080, with reimbursement subject to the provisions of 28 Texas Administrative Code §129.5(i), which states that "The amount of reimbursement shall be $15." This amount is recommended.

3. This dispute regards professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(c), which requires that:

   To determine the MAR [Maximum Allowable Reimbursement] for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83 . . .
   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year.

   The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The MAR is calculated by substituting the Division conversion factor. The applicable Division conversion factor for calendar year 2016 is $56.82.

   For procedure code 99213, service date May 24 2016, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.98843. The practice expense (PE) RVU of 1.01 multiplied by the PE GPCI of 1.006 is 1.01606. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.955 is 0.06685. The sum of 2.07134 is multiplied by the Division conversion factor of $56.82 for a MAR of $117.69. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $95.00. This amount is recommended.

4. The total allowable reimbursement for the services in dispute is $110.00. The insurance carrier has paid $0.00. The amount due to the requestor is $110.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $110.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $110.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	October 28, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.